		SERVICE Use Only)					
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	Issued:						
	Expires						
	ification p. Inven		ort Form []				
	p. mven S Person		oort Form [] Orders []				
		. []					
		APPLICATION FOR C	ERTIFICATION	AS AN "OUTSIDE HO	SPITAL"		
		EME	RGENCY MEDIC				
			MEDEVAC SE	<u>CRVICE</u>			
1.	ORG	GANIZATION/AGENCY I	NFORMATION				
	A.	Date of Application					
	B.	Legal Name of Organizati					
	C.	Mailing Address	(Street)				
			(Silect)				
			(City)	(Zip)			
	ъ.	G 1: 411	(==5)	(-r)			
	D.	Geographic Address (if different from above)		(Street)			
		(ii different from above)		(Succi)			
			(City)	(Zip)			
	E.	Name and Job Title of Ho	ead of Organization	on/Agency			
	F.	Telephone of Head of Org	ganization/Agency	(Business)			
		(Home)					
	G.	Fax (Business)					
		e-mail contact: Web site:					
		24-hour Dispatch number					
2.	INFI	JGHT PATIENT CARE FO)RM				
2.	INCLICITE LATIENT CANETONNI						
	Do y	ou use the Alaska Medevac	Transport Form?	YES [] NO []			
	If "N	If "NO", attach to this page the inflight patient care form your organization uses.					
If you	ı do not	have an inflight patient care	form as required in	n 7 AAC 26.350 and 7 A	AC 26.400(6), the		
Alasl	ka Mede	evac Transport Form may be					

3. PHYSICIAN MEDICAL DIRECTOR

List all physicians who are qualified under 7 AAC 26.630 and who agree to fulfill the responsibilities outlined in 7 AAC 26.610 - 7 AAC 26.700. (If your service has more than two physician medical directors, provide identical information for each.) If your physician medical director is affiliated with the Public Health Service or the military, please indicate state(s) of license and license number. The physician medical director(s) must sign below before the application is submitted.

	A.	(Nameplease print)	(Alaska License #) (Physic	ian's Signature)	
			Board Certified?	YES [] NO []	
		(Specialty Training)		YES[] NO[]	
		(Aeromedical Training)	(Training Organization)	(Date	e Completed)
		(Aeromedical Training)	(Training Organization)	(Date	e Completed)
	В.				
		(Nameplease print)	(Alaska License #) (Physic	ian's Signature)	
			Board Certified?	YES [] NO []	
		(Specialty Training)	Board Eligible?	YES[] NO[]	
		(Aeromedical Training)	(Training Organization)	(Date	Completed)
	Doto Cor	(Aempleted)	eromedical Training)	(Training	g Organization)
(1	Date Co.	тресси)			
4.	CON	ITINUING AEROMEDICAL	EDUCATION		
	Nam	e of person(s) responsible for c	continuing medical education pro	gram:	
	(Nan	ne)		(Phone #)	
	(Nan	ne)		(Phone #)	
	(Nan	ne)		(Phone #)	
	(Nan	ne)		(Phone #)	
5.	Doto	nhysisian signed standing s	orders ware last		h
J.	physi	physician-signed standing of ician.	Reviewe	ed Rev	by vised

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT

The following is a list of the appropriate equipment necessary for medevac services to perform BLS and ALS medical procedures within the skill levels of available certified personnel. Please verify with a check mark that your service has the following equipment and will carry it on the aircraft, when appropriate:

Basic Life Support (BLS) EQUIPMENT/SUPPLIES

VENT	ILATION AND AIRWAY EQUIPMENT:
	Oxygen system to provide 8 liters per minute flow for the longest anticipated medevac flight plus
	45 minutes
	Portable oxygen tank with regulator
	Adult bag-valve-mask with reservoir and mask
	Pediatric bag-valve-mask with reservoir and pediatric mask
	Infant bag-valve-mask with reservoir and infant mask
	Oxygen connection tubing
	Non-rebreathing masks, adult and pediatric sizes
	Oxygen masks, infant
	Oxygen cannulas, adult and pediatric
	Portable suction unit
	Suction catheters (6F-14F)
	Rigid suction tip (e.g., Yankaur)
	Pediatric bulb syringe
	Suction rinsing water bottle
	Oropharyngeal airways (00-5), adult, pediatric, and infant
	Nasopharyngeal airways, sizes 18F-34F or 4.5 - 8.5 mm
	Water-soluable lubricant
11.41.4.6	ODILIZATION FOLUDMENT.
	OBILIZATION EQUIPMENT: Stretcher main with appropriate potient restraining device
	Stretcher, main - with appropriate patient restraining device
	Cervical collars, adult and pediatric
	Cervical immobilization device, adult and pediatric (sandbags may not be used) Long spine board
	Short backboard, KED, or equivalent
	Traction splint, adult and pediatric
	Extremity splints, adult and pediatric (e.g. vacuum, air, padded board, etc.)
	Infant car seat (desirable but not required)
	Restraints, patient
_	Restraints, patient
BAND	PAGING EQUIPMENT:
	Universal dressings or trauma dressings
	4 x 4 gauze pad packs
	Roller bandages (eg., Kerlex or Kling type)
	Adhesive tape, various sizes
	Burn sheets, sterile
	Triangular bandages with safety pins
	Trauma shears
	Occlusive dressings

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued 6. OBSTETRICAL: Obstetrical kit, sterile Thermal blanket (to help newborn maintain body heat) MISCELLANEOUS: Blood pressure cuff, adult, pediatric and infant; in addition, large adult size recommended Stethoscope Activated charcoal, 25-50 grams Substance high in sugar for treatment of diabetic patients Glasgow Coma Scale reference Pediatric Trauma Score reference Emesis basin, urinal, bed pan Blankets Sheets **Pillows** Sterile saline for irrigation Small stuffed toy (desirable but not required) SAFETY: Fire extinguisher appropriate to aircraft Flashlight Body fluid isolation devices and supplies (gloves, masks, gowns, eye protectors) Other EMT-I medications/equipment carried: Advanced Life Support (ALS) FOUIPMENT/SUPPLIES EMT-II EOUIPMENT/SUPPLIES: Advanced Airway Device (Type:) and associated administration equipment Naloxone HCI 50% Dextrose in Water Balanced Salt Solution (e.g., normal saline) Syringes of various sizes Needles of various sizes Three-way Stopcocks (desirable but not required) **Tubes for Blood Samples** Pediatric Medication Dosage Chart IV Catheters (14-24 Gauge) Intraosseous Needles Mini (60 gtts/cc) and Maxi (10, 12, or 15 gtts/cc) IV Sets 6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

	Other EMT-II medications carried:
EM1	T-III EQUIPMENT/SUPPLIES:
	Monitor/Defibrillator Pediatric paddles/patches for defibrillator Monitoring electrodes - adult and pediatric sizes Defibrillator Gel/Pads Lidocaine 1% or 2% Lidocaine 20% or pre-mixed bag for drip Morphine Sulphate Epinephrine 1:1,000 Epinephrine 1:10,000 Atropine
	Other EMT-III medications carried:

6. INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued

PARAMEDIC EQUIPMENT/SUPPLIES: (Please indicate which paramedic medications you carry) Isuproterenol Diphenhydramine Propranolol Furosemide Intropin Aminophylline Diazepam Corticosteroids Varapamil Procanamide Quinidine Nitroglycerin Phentoin Sodium Albuterol Nitrous Oxide Pitocin **Paralytics** Laryngoscope with blades, adult and pediatric sizes ET Tubes (uncuffed sizes 2.5 - 6.0; cuffed sizes 6.0 - 8.0) End tidal CO₂ detection device Magill Forceps – adult and pediatric sizes ET tube stylet - adult and pediatric sizes Other MICP medications carried: _ ____ A. Please place a check mark next to the following optional equipment used by your service: Blood glucose monitoring system Automated external defibrillator Nebulizer system Nasogastric tubes

Please list other optional equipment or supplies you carry which you wish to have listed in your

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records (on attached sheet):

B.

6.	INVENT	ORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued
	C.	Do you have sufficient equipment and medications to provide advanced life support procedures which are outlined in the standing orders signed by your physician medical director?
		YES[] NO[]
	D.	Specify equipment needed or missing and your plans to obtain it:
7.		l equipment been tested in the airborne environment to ensure that it works as designed at high es and does not interfere with the operations of any aircraft in which it will be used?
	YES	S[] NO[]
8.	Is you	r organization/agency requesting a written waiver for revisions to the equipment list?
	YES [] NO [] If "YES", please submit explanation on a signed affidavit.

9. AIRCRAFT INFORMATION FOR PATIENT TRANSPORTS

A.	Does the organization/agency have aircraft available 24 hours a day, 7 days a week, to provide
	patient transport, except when flying conditions are unsafe or the members of the service are
	responding to another emergency? YES [] NO []

B. Does the organization/agency own the aircraft used for transporting patients? YES [] *NO [

*If "NO", list below the air carrier(s) with whom the organization/agency has written agreement(s) in order to provide available transport 24 hours a day, 7 days a week, and attach copies of agreements with this application. If there are more than two air carrier written agreements, submit information for each.

WRITTEN AGREEMENTS WITH AIR CARRIERS

(Legal Name of Air Carrier)	(Legal Name of Air Carrier)		
(Mailing Address)	(Mailing Address)		
(City) (State) (Zip)	(City) (State) (Zip)		
(Name of Agency Head)	(Name of Agency Head)		
(Business Phone of Agency Head)	(Business Phone of Agency Head)		
(Agreement Starting/Ending Date)	(Agreement Starting/Ending Date)		

C. Please list below the type of aircraft either owned by the organization/agency or expected to be used through written agreement(s) and answer if each aircraft has proper restraining devices and litters. For organizations/agencies using more than 8 aircraft, submit information separately.

AIR	RESTRAINING DEVICES	LITTERS		
MAKE	MODEL	YEAR	YES/NO	YES/NO
1.				
2.				
3.				
4.				
5.				
6.				
7.				

10. LICENSED PERSONNEL

List all licensed personnel, such as Emergency Medical Technicians I, II, and III, Mobile Intensive Care Paramedics, Physician's Assistants, Nurse Practitioners, Registered Nurses, or Physicians involved in the transportation and care of patients. (Indicate name, certificate or license number, status, and medevac training status.) If personnel are recertifying with the service, they must have had 16 hours, per certification period, of continuing medical education (CME) in specialized aeromedical patient transportation topics.

NAME	LEVEL OE CERTIF- ICATE/ LICENS E	STATE CERTIE- ICATE/ LICENSE NUMBER	EXPIRA- TION DATE	DATE OF INITIAL AERO- MEDICAL TRAINING ²	# HOURS OF AERO- MEDICAL TRAINING IN 1999- 2000 ³

I affirm that the personnel listed above have hac	I required aeromedical training.	
(Printed Name of Physician Medical Director)	(Signature of Physician Medical Director)	(Date)

¹ If the air ambulance service is not based in Alaska, please list the state in which personnel are licensed and their license numbers.

This refers to department-approved training in accordance with 7 AAC 26.330 (c)(3).

This refers to department-approved training in accordance with 7 AAC 26.370 (a)(3).

11. AFFIRMATION:

I here	by affirm that		will comply with
	all	(Name of Service)	
	and regulations of the 0, including:	Department of Health & Social Services	7 AAC 26.310 - 7 AAC
1)	who has had dependent to prove the patient; or to prove the personnel such as a Critical Care Emergence.	re support, having a certified Emergency Nartment-approved medevac training, to vide advanced life support, having a certified Entransive Care Paramedic, a Nurse Practitioner, Registered Nurse, ergency Nurse, Physician's Assistant, of ed medevac training, to accompany each	accompany each medevace ertified Emergency Medica or other licensed medica Certified Emergency Nurse or Physician, who has have
2)	enable certified or	uing medical education program in medev licensed emergency medical personnel cialized aeromedical patient transport top	to meet state recertification
3)	treated. The form A copy of the comp a) accompany b) be sent to the	oletion of an approved inflight patient care must document vital signs and medical oleted inflight patient care form must the patient to the treatment facility; he physician medical director; and the medevac service as a permanent reco	treatment given the patient.
4)	If advertising, to list personnel for its ser	in any advertisements the levels of certification.	ed or licensed medical
		(Typed Name of Head of Agency/0	Organization)
		(Title)	
		(Signature)	

12. NOTARIZED STATEMENT:

PLEASE COMPLETE SECTION (1) OR (2) BELOW, WHICHEVER IS APPLICABLE:

IN THE PRESENCE OF A NOTARY PUBLIC, POSTMASTER, CLERK OF COURT, JUDGE, MAGISTRATE, STATE TROOPER, OR AUTHORIZED STATE EMPLOYEE, APPLICANT MUST SIGN HERE.

I certify under penalty of perjury that the force	egoing is true and accurate.
(Signature of Applicant)	(Date)
me appeared	day of, 200, before, to me known and known executed the foregoing instrument and acknowledged me.
	My Commission Expires:
(Notary Public, Postmaster, Clerk of Court, Judge, Magistrate, State Trooper, or authorized State employee)	My Badge Number is